54 Lambrinudi : *Madelung's Deformity*

aspect of the lower end of the radius; the epiphyseal line appeared to be indistinct anteriorly, as if prematurely fused.

Moore, writing in the *Journal of Bone and Joint Surgery*,[1] states that there are two classes of cases indiscriminately included under the title of Madelung's deformity. In Madelung's original description in 1878 the carpus was stated to be simply dislocated forward without any associated bone deformity. It was Duplay, in 1885, who drew attention to cases having a similar appearance, but with an associated anterior curve of the radius. This latter variety, of which my cases are an example, is very rare; according to Moore only seventy-five cases have been recorded.

It is commoner in girls, and starts between the ages of 12 to 16 with pain and deformity of the wrist. The pain, which may have been excited by occupation or slight trauma, subsides spontaneously, but the deformity gradually increases, and is presumably brought to an end by the fusion of the epiphysis with the diaphysis at the age of 20.

Such a deformed wrist with limited extension, even though painless, must always be a weak one, as the patient is unable comfortably to place the hand in the position which gives maximum power.

The ætiology of this deformity is obscure. I think the X-ray photograph of I.H. does show premature ossification of the anterior part of the epiphyseal cartilage.

Moore is inclined to class these cases in that ever-increasing group of epiphyseal abnormality of which Perthes' and Köhler's disease are familiar examples, but the cause is still undecided.

Intermittent Œdema of the Foot for Diagnosis.

By C. C. Worster-Drought, M.D.

F. L. J., aged 34.

History.—Enlisted 1916 and stood training well. After several "forced marches" in 1917 began to complain of excessive fatigue, but nevertheless proceeded to France in September, 1917. In January, 1918, he developed "P. U. O," and in May, 1918, was sent back to England with a damaged hand. Later in the same year he was discharged from the Army and remained well until September, 1920, when he began to complain of periodical "swelling" of the right foot. On the first occasion (September, 1920) the swelling lasted one month and did not recur until June, 1921, when it persisted for five months. During the past five years the intervals of remission have become progressively shorter until now, when some degree of œdema is almost always present.

No previous illnesses of importance.

Physical Signs and Progress.—When first seen in July, 1921, the patient presented the following signs: Moderate œdema of right foot, especially of dorsum, extending as far as the ankle and pitting deeply on pressure. Heart: No enlargement and sounds normal. State of arteries good. Pulse 112 rising to 128 on exertion-test, but falling again to 112 within a minute. Dorsalis-pedis and posterior-tibial pulses equal and normal. Pulsatile aorta; vasomotor instability. Liver and spleen not palpable.

Nervous system: Cranial nerves normal, apart from old strabismus; abdominal reflexes brisk and equal and deep reflexes normal.

The swelling of the foot disappeared after five months, but he was not seen again until November, 1921. There was then no œdema of the foot, but his hands were bright-red in colour, and he exhibited general vasomotor instability of cutaneous stimulation.

[1] *Journ. Bone and Joint Surg.*, July, 1924, 568.

The œdema remained absent until February, 1922, when he was again seen. Œdema was then present as before, and in addition there was marked cyanosis of the toes. He was treated with calcium lactate, gr. 10 t.d.s., until October, 1922, without benefit.

From December, 1922, to February, 1923, he received twelve intramuscular injections of "collosol calcium," 1 c.c., at weekly intervals. The œdema was absent for several days during January, 1923.

From February, 1923, to August, 1923, he received twenty-four intravenous injections of "afenil" (calcium-chloride-urea) at weekly intervals. The œdema was absent for short intervals, but no pronounced benefit resulted.

In October, 1923, his walking appeared more difficult, and there was a suggestion of slight spasticity of the right leg. The following physical signs were noted: Pupils and cranial nerves normal; arm-jerks moderate and equal; abdominal and epigastric reflexes absent; knee-jerks brisk, right slightly greater than left; ankle-jerks brisk, right ankle clonus; plantar reflexes flexor. Sensation everywhere normal; co-ordination normal. Other systems normal.

At no time did the urine show any albumin or casts. The blood yielded a negative Wassermann reaction, and the cerebro-spinal fluid showed a normal cell count and negative globulin, Wassermann and colloidal-gold reactions.

During 1925 he complained of occasional weakness of the right arm, but no abnormal signs were detected. At the present time, however, the right arm shows some general wasting as compared with the left ($\frac{3}{4}$ in. wasting forearm, and $\frac{1}{2}$ in. upper arm). Beyond the fact that the knee-jerks are rather brisker, his condition continues much the same. The right knee-jerk is brisker than the left; there is right ankle clonus and the abdominal reflexes remain absent. The plantar reflexes are variable, occasionally weakly extensor, but more often flexor.

COMMENTARY.

The original diagnosis, until the appearance of spasticity in the leg, was "angio-neurotic œdema." With the advent of signs suggesting the development of lateral sclerosis, the question of early syringomyelia was considered, the œdema being a possible, though rare, initial trophic change. Sensation to all forms of stimuli, however, have invariably been normal. At present, one is inclined to regard the case as a very slowly developing and somewhat abnormal form of amyotrophic lateral sclerosis, though even upon that supposition it is difficult to explain the appearance of intermittent œdema of the foot three years before any other sign.

Swelling of Finger.

By A. E. MORTIMER WOOLF, F.R.C.S.

SWELLING inside finger noticed since birth. Getting bigger lately; the mother thinks the swelling increased in ratio to the general growth.

On the palmar aspect of the middle finger (right hand) are two swellings situated on the proximal and intermediate phalanges. There is a smaller swelling on the dorsal aspect of the latter.

There is also a small subcutaneous swelling at the level of the insertion of the right deltoid.

Dr. PARKES WEBER thought the little nodules were neuromata of some kind. There were no molluscous fibromata or patches of cutaneous pigmentation to suggest Recklinghausen's disease.[1]

[1] *Corrigendum.*—These remarks were printed, by an error in the last number of the *Proceedings* (see No. 6, April, Clin. Sect. p. 42).